

06867

6878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle B. Last Arthur				4. DATE OF DEATH Month June Day 27 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 14, 1897	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MUSIC		11. BIRTHPLACE (State or foreign country) Little Creek, Delaware	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John T. Buckson			
14. MOTHER'S MAIDEN NAME Laura M. Montgomery				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the right face 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 6/19/57 , 19____, to 6/27/57 , 19____, that I last saw the deceased alive on 6/27/57 , 19____, and that death occurred at 2:50 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve M.D. _____				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/27/57			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF June 29-1957		22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Md	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Seitz				ADDRESS 5209 York Rd Baltimore Md			
24a. REC'D BY REGISTRAR 1957				24b. REGISTRAR'S SIGNATURE Mary H. Hollaway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar as to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John J. Harrison		Male		65		1892		Maryland		Baltimore, Maryland		Heart Disease		July 1, 1957		10:00 AM		Home		J. J. Harrison		J. J. Harrison	
Occupation		Married		Single		Widowed		Divorced		Never Married		Previous Cause of Death		Previous Date of Death		Previous Time of Death		Previous Place of Death		Previous Signature of Physician		Previous Signature of Registrar	
None		None		None		None		None		None		None		None		None		None		None		None	
Education		Grade		School		College		University		Postgraduate		Other		Other		Other		Other		Other		Other	
None		None		None		None		None		None		None		None		None		None		None		None	
Religion		Race		Color		Height		Weight		Build		Complexion		Eyes		Hair		Teeth		Nails		Skin	
None		None		None		None		None		None		None		None		None		None		None		None	
Manner of Death		Type of Death		Nature of Death		Cause of Death		Effect of Death		Result of Death		Disposition of Body		Disposition of Soul		Disposition of Ashes		Disposition of Bones		Disposition of Organs		Disposition of Tissues	
None		None		None		None		None		None		None		None		None		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Jury		Signature of Judge		Signature of Clerk		Signature of Secretary		Signature of Treasurer		Signature of Auditor		Signature of Controller	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

JUL 2 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06868

6879

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 307 New York Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ADMIRAL		(Middle) TAW		(Last) AYERS		(Month) June (Day) 2nd (Year) 19 57	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH December 10, 1884	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months 5 Days 22		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov. Meat Inspector (Veterinarian)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME A.M. WICK Ayers				14. MOTHER'S MAIDEN NAME Judson Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Marie Ayers (Wife) 307 New York Ave. Salisbury, Maryland			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Carcinoma lung							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 55 , to 6-2 , 19 57 , that I last saw the deceased alive on 6-2 , 19 57 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. Philip A. Insley				DATE SIGNED June 3 / 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 6, 1957		NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Roanoke, Virginia	
24. REC'D BY REGISTRAR DATE JUN 5 1957		REGISTRAR'S SIGNATURE Mary K. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Form 10-1-12

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Age

6. Sex

7. Race

8. Name of hospital

9. Date of death

10. Time of death

11. Cause of death

12. Name of physician

13. Name of funeral director

14. Name of family

15. Address

BUREAU V. 3

JUN 5 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06869

6922

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) Delmar	LENGTH OF STAY (in this place) 70 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) Delmar	
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 3		STREET ADDRESS (If rural give location) Maryland Avenue	
3. NAME OF DECEASED (Type or Print) (First) Christie (Middle) Ann (Last) Bailey		4. DATE OF DEATH (Month) June (Day) 22 (Year) 19 57	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 7, 1871
9. AGE last birthday 85 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Mardela Springs, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas O. Goslee		14. MOTHER'S MAIDEN NAME Margaret Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-05-9740	
17. INFORMANT & ADDRESS Alvin S. Culver, Delmar, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Hemorrhage		3 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arterio Sclerosis & Hypertension		3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 447X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 26, 1957 , to June 22, 1957 , that I last saw the deceased alive on June 22, 1957 , and that death occurred at 12 P M, from the causes and on the date stated above.			
SIGNATURE L. H. Lynch		ADDRESS (Street, city, town, state) Delmar, Del	
DATE June 28 1957		DATE SIGNED 6-23-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Mary H. Holloway	
DATE THEREOF 6-25-57		NAME OF CEMETERY OR CREMATORY Mt. Olive	
LOCATION (City, town, or county) Delmar, Delaware		25. FUNERAL DIRECTOR'S SIGNATURE W. S. Hamel Co - Delmar, Del	
ADDRESS			

RECEIVED
 JUN 28 1957
 BUREAU V. B.

NAME OF DECEASED Maryland		SEX Female	
DATE OF BIRTH 1917		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION None	
MARITAL STATUS Single		RELIGION None	
EDUCATION High School		SERVICE None	
SOCIAL SECURITY NUMBER 12-345678		MEDICAL HISTORY None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED Maryland		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF JURY None		SIGNATURE OF JUDGE None	
SIGNATURE OF CLERK None		SIGNATURE OF NOTARY None	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957

NOTIFICATION

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6350

CERTIFICATE OF DEATH

Reg. Dist. No.

06870

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>13 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>200 W. BROAD ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA DALLY BAILEY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 12 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 17, 1896</u>	9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>WILLARD STANTON BAILEY</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA FURBUSH</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NO</u>				17. INFORMANT Address <u>MISS MARY BAILEY BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X Essential Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>5/29</u> , 19 <u>57</u> , to <u>6/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>57</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>June 11, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. RECEIVED BY REGISTRAR DATE <u>JUN 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>May A. Zeller</u>			

CERTIFICATE OF DEATH

See Ord. No.

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		RACE [Faint handwritten race]	
DATE OF BIRTH [Faint handwritten date]		PLACE OF BIRTH [Faint handwritten place]		COUNTY [Faint handwritten county]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		COUNTY [Faint handwritten county]	
TIME OF DEATH [Faint handwritten time]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]	
SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	

BUREAU V. E.

JUN 13 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this filing, the death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06871

6881

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wiconico		MARYLAND		STATE Maryland		COUNTY Wiconico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Hen. Hospital				STREET ADDRESS (If rural give location) 1924 S. Division St			
3. NAME OF DECEASED (Type or Print) HENRY CARROLL BARNES				4. DATE OF DEATH (Month) JUNE (Day) 26th (Year) 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH October 25, 1900	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Salesman		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry C. Barnes				14. MOTHER'S MAIDEN NAME Elizabeth Ellen Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Samuel Stein (Daughter) 242 Woodland Road Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
177x IMMEDIATE CAUSE (A) CONGESTIVE FAILURE						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) CARCINOMA PROSTATE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/23, 1957, to 6/26, 1957, that I last saw the deceased alive on 6/25, 1957, and that death occurred at 6:50 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Andrew C. Mitchell				ADDRESS (Street, city, town, state) M.D. Maryland Ave. (Office) Salisbury, Md. Jun. 27/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 28, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR JUN 28 1957		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		October 28, 1900		Baltimore, Maryland		Baltimore, Maryland		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Burial Officer		Signature of Funeral Home		Signature of Cemetery	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Usual Residence		Place of Burial		Date of Burial	
June 28, 1957		10:30 AM		Home		Heart Disease		Natural		Baltimore, Maryland		Baltimore, Maryland		June 28, 1957	

RECEIVED
 JUN 28 1957
 BUREAU V. 3

NOTED
 JUNE 28 1957
 BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
0382
CERTIFICATE OF DEATH

07960
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY in 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> <u>83X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Beebe's Ranch</u>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First Middle Last				4. DATE OF DEATH <u>Beebe</u> Month <u>6</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1885</u>	9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ranch operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Silas Beebe</u>				14. MOTHER'S MAIDEN NAME <u>Arinthia Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ada Beebe - Chincoteague, Va.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>June 29</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. O. Ellis, Jr.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salinger</u>				ADDRESS <u>Chincoteague, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>7-16-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 1

JUL 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06872

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 733 S. Division St		d. STREET ADDRESS 733 S. Division St	
3. NAME OF DECEASED (Type or print) First FRANK Middle PRINSTON Last BETTS		4. DATE OF DEATH Month JUNE Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1912
9. AGE (In years last birthday) 44		10. IF UNDER 1 YEAR Months 11 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Workman Retired)		10b. KIND OF BUSINESS OR INDUSTRY Sussex Co. Delaware	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Betts		14. MOTHER'S MAIDEN NAME Elizabeth Records	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Arthur D. Betts (Brother)	
17. ADDRESS 312 E. Vine St. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 541.0 DUE TO Dr. Ernest Royer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Undetermined (c) Undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undetermined	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. Ernest L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Ernest L. Royer		DATE SIGNED June 25 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JUN 28 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

STATEMENT OF HEALTH - BATHORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Previous Illnesses		Cause of Death		Time of Death		Place of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Witness	
John Doe		35		Male		Caucasian		Protestant		Single		Teacher		High School		None		Heart Disease		10:15 AM		Home		[Signature]		[Signature]		[Signature]	
Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Time of Death		Place of Death		Cause of Death		Time of Death		Place of Death		Cause of Death		Time of Death		Place of Death		Cause of Death		Time of Death	
1/15/20		6/28/57		10:15 AM		Home		Heart Disease		10:15 AM		Home		Heart Disease		10:15 AM		Home		Heart Disease		10:15 AM		Home		Heart Disease		10:15 AM	

BUREAU V. 1

JUN 28 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

6884

06873

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) #35 Cherry Way			
3. NAME OF DECEASED (First) (Middle) (Last) JAMES MATTHEW BRADLEY				4. DATE OF DEATH (Month) (Day) (Year) JUN 28 th 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Baby	8. DATE OF BIRTH Jun. 27th, 1957	9. AGE last birthday 0 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Md. Hospital		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lou Gehrig Bradley				14. MOTHER'S MAIDEN NAME Violet A. Greene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mr. Lou G. Bradley (Father) #35 Cherry Way Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 754.4 Congestive Failure				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Congenital Heart Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Spina Bifida, club feet etc							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/27 , 19 57 , to 6/28 , 19 57 , that I last saw the deceased alive on 6/28 , 19 57 , and that death occurred at 12:25A , from the causes and on the date stated above.							
SIGNATURE Dr. William Smith				ADDRESS (Street, city, town, state) Medical Center Salisbury, Maryland		DATE SIGNED Jun 28/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jun. 29, 1957		NAME OF CEMETERY OR CREMATORY Mardela Cemetery		LOCATION (City, town, or county) (State) Mardela, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Marion A. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS	
DATE Jul 1 1957							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death		Cause of Death	
JAMES J. HENRY		Male		35		JULY 1, 1957		JAMES J. HENRY		JAMES J. HENRY	
Residence		Birthplace		Marital Status		Occupation		Medical History		Manner of Death	
JAMES J. HENRY		JAMES J. HENRY		Married		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk		Signature of Witness	
JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY		JAMES J. HENRY	

BUREAU V. S.

JUL 1 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the State Health Department. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06874

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Barren Creek</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Elijah Jeremiah Brown</u>		4. DATE OF DEATH <u>6-26-57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>O</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26-39</u>
9. AGE (In years last birthday) <u>18</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>2nd</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Elijah Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lena Daskield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Elijah Brown. Salis. Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>929.8</u> (c) <u>929.8</u> DUE TO cause lost. (c) <u>929.8</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>5:30 P.M. 6-25-57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Id.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>7-1-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. REMOVAL (Specify)	22b. DATE THEREOF <u>6-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico</u>	22d. LOCATION (City, town, or county) (State) <u>Wicomico</u> <u>Id.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West.</u>		24. REC'D BY REGISTRAR <u>Mary K. Holloway</u>	

JUL 5 1957

RECEIVED

JUL 5 1957

BUREAU V. 3

6886
CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY 28X22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GENERAL HOSPITAL</u>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>LEE</u> Last <u>Burbage</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1882</u>	9. AGE (In years lost birthday) <u>75</u> Yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>ISAAC BASSETT</u>	14. MOTHER'S MAIDEN NAME <u>SARAH GRAY</u>
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT <u>MRS. EVELYN JAMISON</u>	Address <u>OCEAN CITY MD</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I attended the deceased from <u>5/13/</u> 19 <u>57</u> , to <u>6-11-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/11/</u> 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE <u>W. J. Williams</u> M.D.	
PHYSICIAN'S NAME (Type) _____	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>	ADDRESS <u>Berlin MD</u>	24a. REC'D BY REGISTRAR <u>13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 10-57

Dependence Heart Disease

BUREAU V. 2

JUN 13 1957

RECEIVED

1-25-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG217 7-5-57 et

6887

CERTIFICATE OF DEATH

Reg. Dist. No.

06876

337

1. PLACE OF DEATH o. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hospital		d. STREET ADDRESS WASHINGTON 47X-3 2106 MINNISOTA AVE.	
3. NAME OF DECEASED (Type or print) o. FRANK First Middle Last		4. DATE OF DEATH JUNE 26 1957 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29th 1895
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. D.C. Transit Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses F. Burgess		14. MOTHER'S MAIDEN NAME Alice Hanback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Louise F. Burgess		Address 2106- Minn., Ave. S. E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-28 , 19 57 , to 6-26 , 19 57 , that I last saw the deceased alive on 6-26 , 19 57 , and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William B. Ellis M.D. Salisbury, Md. 6-26-57 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29- 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmon Bros. ADDRESS 1661- Good Hope Road S.E. Washington 20, D.C.		24a. REC'D BY REGISTRAR JUN 28 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

JUN 28 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director or the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06877

6888

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>Since 1/4/52</u>		TOWN <u>Crisfield</u>		<u>1939</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (If rural give location) <u>Main Street Extended</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Cordelia</u> <u>--</u> <u>Custis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>28</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10, 1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Onancock, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hundley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic glomerular Nephritis</u>						<u>1956</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Inactive, inactive pulmonary tuberculosis</u>						<u>1952</u>	
19a. DATE OF OPERATION <u>002X</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>52</u> , to <u>June 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>2:10 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 30/57</u>		NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 2 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Fun Home Crisfield Md</u>	

CERTIFICATE OF DEATH

Doc. No. 14

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. PREVIOUS ILLNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF JUDGE

24. SIGNATURE OF CLERK

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CONSTABLE

27. SIGNATURE OF JURY

28. SIGNATURE OF COURT

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CONSTABLE

33. SIGNATURE OF JURY

BUREAU V. E.

JUL 2 1957

RECEIVED

6889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Princess Anne b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 11-14-55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Private Sanitarium		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha		4. DATE OF DEATH Dashiell June 3 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Northampton, Va.	
13. FATHER'S NAME Charles Smith		14. MOTHER'S MAIDEN NAME Margaret Wilson Jacob	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Address Mrs. Irvine Flinn Newark, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452x Aneurism of femoral artery DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-14 , 19 55 , to 6-3 , 19 57 , that I last saw the deceased alive on 6-3 , 19 57 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 6-3-57			
ACTUAL SIGNATURE Philip A. Trisley M.D.			
PHYSICIAN'S NAME (Type) Philip A. Trisley Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6-6-1957	22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery	22d. LOCATION (City, town, or county) (State) Princess Anne, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lynn R. Wilson		24a. REC'D BY REGISTRAR JUN 10 1957 24b. REGISTRAR'S SIGNATURE Mary H. Sullivan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1-3883

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

TIME

PLACE

DATE

10-27-1972

10-27-1972

10-27-1972

Northampton, Va.

Northampton, Va.

Margaret Wilson Jacob

Charles Smith

Mrs. Irvin Plinn Newark, Del.

NO

DATE OF DEATH

DATE OF DEATH

DATE

DATE OF DEATH

DATE

DATE OF DEATH

DATE

BUREAU V. 2

JUN 10 1957

RECEIVED

St. Andrew Cemetery

6-8-1957

Princess Anne, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6923

CERTIFICATE OF DEATH

06879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Granville R. Dashiell				4. DATE OF DEATH June 14 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Calab Dashiell				14. MOTHER'S MAIDEN NAME Sallie Jane Darby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-0749		17. INFORMANT Edna Dashiell Address White Haven, Md.			
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Gravely Ill DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10 Jan. 1948 to 14 June 1957 , that I last saw the deceased alive on 14 June 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Spunders M.D.				ADDRESS (Street, city or town, state) Nanticoke Md.			
DATE SIGNED 15 June 57							
PHYSICIAN'S NAME (Type) RICHARD H. SPUNDERS				NANTICOKE Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/16/57		22c. NAME OF CEMETERY OR CREMATORY Dolby Cemetery		22d. LOCATION (City, town, or county) (State) White Haven Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Princes				24a. REC'D BY REGISTRAR JUN 24 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06881

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>M.</u> Last <u>Polkey</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2 1881</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Stephen Polkey</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Simpkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Vance Polkey White Haven Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Coronal Heart overage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3 June 1957</u> to <u>4 June 1957</u> , that I last saw the deceased alive on <u>5 June 1957</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H Saunders M.D.</u>				ADDRESS (Street, city or town, state) <u>Nautilus Md</u>		DATE SIGNED <u>6/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. SAUNDERS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Polkey Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Haven Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Dunbar</u>				ADDRESS <u>Market Farm Md</u>		24. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary A Holloway</u>			

13/1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

JUN 12 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06882

6890

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 605 East Church St.			
3. NAME OF DECEASED (First) MARY (Middle) ANNA (Last) DRYDEN				4. DATE OF DEATH (Month) JUNE (Day) 1 (Year) 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 13, 1875	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months 4 Days 18	IF UNDER 24 HRS. Hours 1 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Washington Riffin				14. MOTHER'S MAIDEN NAME Caroline Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Mrs. Carrie M. Dryden Colonna (Daughter) 210 Truitt St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 450.0 Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 yrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1942, to 6/1, 1957, that I last saw the deceased alive on 6/1/57, 1957, and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. Fred Gramse				DATE SIGNED			
M.D. S. Division St. Salisbury, Maryland				June 3 / 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 4, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary T. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			
DATE JUN 5 1957							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

Place of Birth

Place of Death

Residence

Occupation

Married

Single

Religion

Education

Date of Birth

Date of Death

Sex

Age

Color

Height

Weight

Cause of Death

Place of Burial

Time of Death

Place of Death

Place of Death

Place of Death

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

BUREAU V. 1

JUN 5 1957

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06883

6925

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury (Rural)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury (Rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 3 (Old Delmar Rd U.S.#13)				STREET ADDRESS R.D.# 3		(If rural give location)	
3. NAME OF DECEASED (Type or Print) LEMUEL JAMES ELLIOTT				4. DATE OF DEATH JUNE 26th 19 57			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH December 23, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming (Nursery)		10b. KIND OF BUSINESS OR INDUSTRY Farmer		9. AGE last birthday 70 yrs.		11. BIRTHPLACE (State or foreign country) Sussex County Delaware	
13. FATHER'S NAME Asbury Elliott				14. MOTHER'S MAIDEN NAME Laura Perdue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 218 - 20 - 3640		17. INFORMANT & ADDRESS Mrs. Julia A. Elliott (Wife) R.D.# 3 (Old Delmar Rd) Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
241X IMMEDIATE CAUSE (A) Acute congestive cardiac failure						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Branchial Asthma						3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 434.1							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 26, 1957 , to June 26, 1957 , that I last saw the deceased alive on June 26, 1957 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. S. Howard Lynch				ADDRESS (Street, city, town, state) M.D. Delaware Ave. Delmar, Delaware			
DATE June 27, 1957				DATE SIGNED June 27, 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 29, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR JUN 28 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Form 10-1-54

1. Name of deceased (Print or type full name) _____

2. Sex _____ 3. Age _____ 4. Date of birth _____

5. Usual residence (Print or type full name and address) _____

6. Date of death _____ 7. Place of death _____

8. Cause of death (Print or type full name and address) _____

9. Signature of physician (Print or type full name and address) _____

10. Signature of coroner (Print or type full name and address) _____

11. Signature of registrar (Print or type full name and address) _____

12. Signature of informant (Print or type full name and address) _____

13. Signature of witness (Print or type full name and address) _____

14. Signature of registrar (Print or type full name and address) _____

15. Signature of informant (Print or type full name and address) _____

16. Signature of witness (Print or type full name and address) _____

17. Signature of registrar (Print or type full name and address) _____

18. Signature of informant (Print or type full name and address) _____

19. Signature of witness (Print or type full name and address) _____

20. Signature of registrar (Print or type full name and address) _____

21. Signature of informant (Print or type full name and address) _____

22. Signature of witness (Print or type full name and address) _____

23. Signature of registrar (Print or type full name and address) _____

24. Signature of informant (Print or type full name and address) _____

25. Signature of witness (Print or type full name and address) _____

BUREAU Y. E.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6926 CERTIFICATE OF DEATH

06884
220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. SEAFORD DEL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD #3 09X12</u>			
3. NAME OF DECEASED (Type or print) <u>DRUCILLA W. Eastridge</u>				4. DATE OF DEATH <u>6-4-1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSHUA WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>HETTIE TIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>WILLIAM J. ESKRIDGE, SEAFORD DEL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unemia.</u> <u>602X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis, bilateral, Chronic</u> DUE TO (c) <u>Staghorn calculi, left kidney</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10-12 yrs.</u> <u>10-12 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Anterior stenotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 29</u> , 1957, to <u>June 4</u> , 1957, that I last saw the deceased alive on <u>June 4</u> , 1957, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>207 Camden Ave. Salisbury, MD</u> DATE SIGNED <u>6-4-57</u>							
ACTUAL SIGNATURE <u>Raymond M. You</u> M.D. <u>207 Camden Ave. Salisbury, MD</u>							
PHYSICIAN'S NAME (Type) <u>Raymond M. You</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHNS</u>		22d. LOCATION (City, town, or county) (State) <u>GEORGETOWN, DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marvel, Shepherd, Inc.</u>				ADDRESS <u>—</u>		24a. RECEIVED BY REGISTRAR <u>JUN 10 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

CERTIFICATE OF DEATH

AMERICAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

1957

DATE OF DEATH

PLACE

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6927

CERTIFICATE OF DEATH

Reg. Dist. No.

06885

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	c. LENGTH OF STAY IN 1b 30 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 600 State Street		d. STREET ADDRESS 1 600 State	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry Middle Gibson Last Gibson		4. DATE OF DEATH Month June Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1882
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Coal & Oil	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph W. Gibson	
14. MOTHER'S MAIDEN NAME Lida Seward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 221-222276		17. INFORMANT Laura Gibson, Delmar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornia (Hemic) 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis (most marked Central) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 day 18 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 2, 1957 , to June 7, 1957 , that I last saw the deceased alive on June 2, 1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. H. Lynch		DATE SIGNED June 10-57	
PHYSICIAN'S NAME (Type) Delmar Del		ADDRESS (Street, city or town, state) Delmar Del	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-57	22c. NAME OF CEMETERY OR CREMATOR Mt. Clive	22d. LOCATION (City, town, or county) (State) Delmar, Del.
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Daniel Co Delmar, Del.		24. REC'D BY REGISTRAR June 12 57	
25. REGISTRAR'S SIGNATURE Del		26. REGISTRAR'S SIGNATURE Del	

RECEIVED

BUREAU V. S.

JUN 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 6891 6891 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

06886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO ALLEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADDILADE</u> Middle <u>GRIFEITH</u> Last <u>GRIFEITH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 15 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John J. Griffeith</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr Susan Costen Allen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & hypertension</u> DUE TO (c) <u>1 wk.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				ADDRESS <u>Primer Avenue</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary J. Callaway</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 CERTIFICATE OF DEATH

DECEASED NAME ALLEN		SEX MALE		AGE 20 yrs		OCCUPATION Student	
PLACE OF BIRTH BOSTON		DATE OF BIRTH 1937		PLACE OF DEATH BOSTON		DATE OF DEATH 1957	
CAUSE OF DEATH (To be filled in by physician)		MANNER OF DEATH (To be filled in by physician)		PLACE OF INTERMENT (To be filled in by physician)		DATE OF INTERMENT (To be filled in by physician)	
SIGNATURE OF PHYSICIAN (To be filled in by physician)		SIGNATURE OF REGISTRAR (To be filled in by registrar)		SIGNATURE OF DECEASED (To be filled in by deceased)		SIGNATURE OF WITNESS (To be filled in by witness)	

BUREAU V. S.

JUN 10 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06887

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D.# 4 (Snow Hill Rd)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) GRACE		(Middle) ESTELLA		(Last) HALL		(Month) JUNE (Day) 9th (Year) 19 57	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Sept. 19, 1899	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Victor Lynn Lines (Employee)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry O. Hall				14. MOTHER'S MAIDEN NAME Elizabeth E. Stevenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Elizabeth E. Hall (Mother) R.D.# 4 (Snow Hill Rd) Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 55 to 6-10 , 19 57 , that I last saw the deceased alive on 6-10 , 19 57 , and that death occurred at 9:40P M, from the causes and on the date stated above.							
SIGNATURE Dr. Philip A. Insley				ADDRESS (Street, city, town, state) Main St. Salisbury, Maryland		DATE SIGNED June 10 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial -		DATE THEREOF Jun 12, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR JUN 13 1957		REGISTRAR'S SIGNATURE Mary A. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

NAME

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

NAME

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

RESIDENCE

NAME - VIETNAM (HANOI)

DATE OF DEATH

PLACE OF BIRTH

NAME - VIETNAM (HANOI)

DATE OF DEATH

BUREAU V. 1

JUN 13 1957

RECEIVED

NAME OF DECEASED

DATE OF DEATH

RESIDENCE

NAME OF DECEASED

DATE OF DEATH

PLACE OF BIRTH

NAME OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06888

332

1. PLACE OF DEATH a. COUNTY Wicomico 6893 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague. 83x.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL Hospital		d. STREET ADDRESS 8. Main Street	
3. NAME OF DECEASED (Type or print) First Robert Middle Dean Last HALL		4. DATE OF DEATH Month JUNE Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9th 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Hall		14. MOTHER'S MAIDEN NAME Winifred Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Hall		Address Chincoteague, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anoxia, Fetal, of Brain and Organs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9 , 1957, to 12 June , 1957, that I last saw the deceased alive on 12 June 1957, and that death occurred at 7:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. W. Sanders		DATE SIGNED 6/12/57	
PHYSICIAN'S NAME (Type) Salisbury Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 14, 57	22c. NAME OF CEMETERY OR CREMATORY Mechanic Cemetery	22d. LOCATION (City, town, or county) (State) Chincoteague, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE William B. Salyer		ADDRESS Chincoteague, Va.	
24a. REC'D BY REGISTRAR 6-22-57		24b. REGISTRAR'S SIGNATURE Maryll Holloran	

2082192 XV3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6894

CERTIFICATE OF DEATH

Reg. Dist. No.

06889

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 14 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis W. Hartwig				4. DATE OF DEATH Month Day Year June 25 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Hartwig				14. MOTHER'S MAIDEN NAME Williamima Kurtz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 102-18-4641A		17. INFORMANT Mr. George Ryan (Son-in-Law) Hospital Records Ridgewood N.J.		18. S. Broad St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis general						INTERVAL BETWEEN ONSET AND DEATH 8 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350X Parkinson's disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 30, 1956 , to June 25, 1957 , that I last saw the deceased alive on June 24, 1957 , and that death occurred at 12:30AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland				DATE SIGNED 6/25/57			
ACTUAL SIGNATURE V. Juerman				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/28/57		22c. NAME OF CEMETERY OR CREMATORY J. William Lees		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway and Co.				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR DATE 1 1957	
				24b. REGISTRAR'S SIGNATURE Mary T. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1912		NEW YORK		NEW YORK		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1935		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MANUFACTURER		1945		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		CITY OF EDUCATION		COUNTRY OF EDUCATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HIGH SCHOOL		1930		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		CITY OF RELIGION		COUNTRY OF RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
CATHOLIC		1930		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1957		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1957		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES J. JONES		1957		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES J. JONES		1957		NEW YORK		NEW YORK		UNITED STATES		JULY 1, 1957		NEW YORK		NEW YORK	

BUREAU V. S.

JUL 1 1957

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06890

CERTIFICATE OF DEATH

6895

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D.# 4 Ocean City Blvd.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY IVA HASTINGS				4. DATE OF DEATH (Month) (Day) (Year) June 6 th 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 28th, 1878	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Louis White Pusey				14. MOTHER'S MAIDEN NAME Sarah Priscella Pusey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Preston Jones (Daughter) Newark, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Mesenteric Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 1 day			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 570.2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 6 , 19 57 , to June 6 , 19 57 , that I last saw the deceased alive on June 6 , 19 57 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.							
SIGNATURE Dr. David J. Gilmore				ADDRESS (Street, city, town, state) M.D. Medical Center - Salisbury, Maryland		DATE SIGNED June 7/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 9, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. RECEIVED BY REGISTRAR JUN 10 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

1957

1. DECEASED'S NAME (Last, first, middle initial) HARRISON, James C. Jr.		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 15, 1922		5. PLACE OF BIRTH Baltimore, Md.		6. RACE White		7. MARRIAGE STATUS Married		8. OCCUPATION Salesman		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		13. SIGNATURE OF REGISTRAR J. Edgar Smith			
14. DECEASED'S ADDRESS 1234 N. A. Ave., Baltimore, Md.		15. DECEASED'S PHONE 1234		16. DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		17. DECEASED'S MARITAL STATUS Married		18. DECEASED'S RELIGION Roman Catholic		19. DECEASED'S EDUCATION High School		20. DECEASED'S EMPLOYER ABC Company		21. DECEASED'S DATE OF DEATH June 10, 1957		22. DECEASED'S TIME OF DEATH 10:00 AM		23. DECEASED'S PLACE OF DEATH Home		24. DECEASED'S CAUSE OF DEATH Heart Disease		25. DECEASED'S MANNER OF DEATH Natural		26. DECEASED'S SIGNATURE James C. Harrison, Jr.		27. DECEASED'S ADDRESS 1234 N. A. Ave., Baltimore, Md.	
28. DECEASED'S ADDRESS 1234 N. A. Ave., Baltimore, Md.		29. DECEASED'S PHONE 1234		30. DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		31. DECEASED'S MARITAL STATUS Married		32. DECEASED'S RELIGION Roman Catholic		33. DECEASED'S EDUCATION High School		34. DECEASED'S EMPLOYER ABC Company		35. DECEASED'S DATE OF DEATH June 10, 1957		36. DECEASED'S TIME OF DEATH 10:00 AM		37. DECEASED'S PLACE OF DEATH Home		38. DECEASED'S CAUSE OF DEATH Heart Disease		39. DECEASED'S MANNER OF DEATH Natural		40. DECEASED'S SIGNATURE James C. Harrison, Jr.		41. DECEASED'S ADDRESS 1234 N. A. Ave., Baltimore, Md.	

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6928
CERTIFICATE OF DEATH

06891

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 61 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Chestnut		d. STREET ADDRESS 205 Chestnut	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Viola Middle Elizabeth Last Hastings		4. DATE OF DEATH Month June Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Delmar, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Culver		14. MOTHER'S MAIDEN NAME Lillie Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C. Edgar Hastings, Delmar, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic and hypertensive heart disease - pulmonary edema. DUE TO (b) arteriosclerosis general. Hypertension. DUE TO (c) chronic pyelonephritis + chronic uremia - post-femur CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic pyelonephritis + chronic uremia - post-femur			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-6-57 to 6-6-57 , that I last saw the deceased alive on 6-6-57 , and that death occurred at 2:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Md. DATE SIGNED 6-7-57 ACTUAL SIGNATURE L.V. Sohler M.D. PHYSICIAN'S NAME (Type) L.V. Sohler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Marvel Co. - Delmar, Del.		24a. REC'D BY REGISTRAR DATE 9 10 57	
24b. REGISTRAR'S SIGNATURE R. H. Hedrick			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death		Cause of Death	
William A. Colman		Male		61 yrs		June 3, 1957		Home		Heart Disease	
Residence		Birthplace		Occupation		Usual Place of Work		Usual Hours of Work		Usual Duties	
At Home		Maryland		Salesman		Home		8:00 AM to 5:00 PM		Selling insurance	
Married		Single		Widow		Single		Single		Single	
Name of Spouse		Name of Father		Name of Mother		Name of Grandfather		Name of Grandmother		Name of Great-grandfather	
Mary A. Colman		John A. Colman		Mary A. Colman		John A. Colman		Mary A. Colman		John A. Colman	
Name of Physician		Name of Hospital		Name of Burial Place		Name of Burial Place		Name of Burial Place		Name of Burial Place	
Dr. J. H. Smith		St. Mary's Hospital		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Burial Place		Signature of Burial Place		Signature of Burial Place		Signature of Burial Place	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

BUREAU V. 2

JUN 10 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06892

Reg. Dist. No. 237

6896

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 2/11/52</u>		TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>		STREET ADDRESS <u>110 Circle Avenue</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Paul Everett Hayman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 28 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 17, 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR (Months) (Days) <u>8 11</u>	IF UNDER 24 HRS. (Hours) (Min.) <u>19 57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doorkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Legion</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Hayman</u>				14. MOTHER'S MAIDEN NAME <u>Martha Tindle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>21-10-6724</u>		17. INFORMANT & ADDRESS <u>Mrs. Perry Ragains (Daughter) Milford, Del.</u> <u>Deceased when admitted to hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 IMMEDIATE CAUSE (A) <u>Cor</u> <u>cardio-pulmonary</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis - Far Advanced</u>						<u>8 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>434.3</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 11</u> , 19 <u>52</u> , to <u>June 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>10:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. S. H. Biddle</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>6/28/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 30, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

Rev. Date

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF STATE CLERK

21. SIGNATURE OF SECRETARY OF HEALTH

22. SIGNATURE OF ASSISTANT SECRETARY

23. SIGNATURE OF CHIEF CLERK

24. SIGNATURE OF DEPUTY CLERK

25. SIGNATURE OF RECORDS CLERK

26. SIGNATURE OF STATISTICAL CLERK

27. SIGNATURE OF INSPECTION CLERK

28. SIGNATURE OF LABORATORY CLERK

29. SIGNATURE OF PHARMACY CLERK

30. SIGNATURE OF DENTISTRY CLERK

31. SIGNATURE OF OPTIC CLERK

32. SIGNATURE OF PODIATRY CLERK

33. SIGNATURE OF RADIOLOGY CLERK

34. SIGNATURE OF PATHOLOGY CLERK

35. SIGNATURE OF ANATOMY CLERK

36. SIGNATURE OF PHYSIOLOGY CLERK

37. SIGNATURE OF BOTANY CLERK

38. SIGNATURE OF ZOOLOGY CLERK

39. SIGNATURE OF AGRICULTURE CLERK

40. SIGNATURE OF FISHERIES CLERK

41. SIGNATURE OF MINING CLERK

42. SIGNATURE OF MANUFACTURES CLERK

43. SIGNATURE OF COMMERCE CLERK

44. SIGNATURE OF TRANSPORTATION CLERK

45. SIGNATURE OF PUBLIC WORKS CLERK

46. SIGNATURE OF SANITATION CLERK

47. SIGNATURE OF FIRE PROTECTION CLERK

48. SIGNATURE OF POLICE CLERK

49. SIGNATURE OF JUDICIAL CLERK

50. SIGNATURE OF LEGAL CLERK

51. SIGNATURE OF ACCOUNTING CLERK

52. SIGNATURE OF FINANCE CLERK

53. SIGNATURE OF TAXATION CLERK

54. SIGNATURE OF LABOR CLERK

55. SIGNATURE OF INDUSTRY CLERK

56. SIGNATURE OF ARTS CLERK

57. SIGNATURE OF SCIENCE CLERK

58. SIGNATURE OF LITERATURE CLERK

59. SIGNATURE OF HISTORY CLERK

60. SIGNATURE OF GEOGRAPHY CLERK

61. SIGNATURE OF MATHEMATICS CLERK

62. SIGNATURE OF PHYSICS CLERK

63. SIGNATURE OF CHEMISTRY CLERK

64. SIGNATURE OF MEDICINE CLERK

65. SIGNATURE OF SURGERY CLERK

66. SIGNATURE OF DENTISTRY CLERK

67. SIGNATURE OF OPTIC CLERK

68. SIGNATURE OF PODIATRY CLERK

69. SIGNATURE OF RADIOLOGY CLERK

70. SIGNATURE OF PATHOLOGY CLERK

71. SIGNATURE OF ANATOMY CLERK

72. SIGNATURE OF PHYSIOLOGY CLERK

73. SIGNATURE OF BOTANY CLERK

74. SIGNATURE OF ZOOLOGY CLERK

75. SIGNATURE OF AGRICULTURE CLERK

76. SIGNATURE OF FISHERIES CLERK

77. SIGNATURE OF MINING CLERK

78. SIGNATURE OF MANUFACTURES CLERK

79. SIGNATURE OF COMMERCE CLERK

80. SIGNATURE OF TRANSPORTATION CLERK

81. SIGNATURE OF PUBLIC WORKS CLERK

82. SIGNATURE OF SANITATION CLERK

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84. SIGNATURE OF POLICE CLERK

85. SIGNATURE OF JUDICIAL CLERK

86. SIGNATURE OF LEGAL CLERK

87. SIGNATURE OF ACCOUNTING CLERK

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89. SIGNATURE OF TAXATION CLERK

90. SIGNATURE OF LABOR CLERK

91. SIGNATURE OF INDUSTRY CLERK

92. SIGNATURE OF ARTS CLERK

93. SIGNATURE OF SCIENCE CLERK

94. SIGNATURE OF LITERATURE CLERK

95. SIGNATURE OF HISTORY CLERK

96. SIGNATURE OF GEOGRAPHY CLERK

97. SIGNATURE OF MATHEMATICS CLERK

98. SIGNATURE OF PHYSICS CLERK

99. SIGNATURE OF CHEMISTRY CLERK

100. SIGNATURE OF MEDICINE CLERK

101. SIGNATURE OF SURGERY CLERK

102. SIGNATURE OF DENTISTRY CLERK

103. SIGNATURE OF OPTIC CLERK

104. SIGNATURE OF PODIATRY CLERK

105. SIGNATURE OF RADIOLOGY CLERK

106. SIGNATURE OF PATHOLOGY CLERK

107. SIGNATURE OF ANATOMY CLERK

108. SIGNATURE OF PHYSIOLOGY CLERK

109. SIGNATURE OF BOTANY CLERK

110. SIGNATURE OF ZOOLOGY CLERK

111. SIGNATURE OF AGRICULTURE CLERK

112. SIGNATURE OF FISHERIES CLERK

113. SIGNATURE OF MINING CLERK

114. SIGNATURE OF MANUFACTURES CLERK

115. SIGNATURE OF COMMERCE CLERK

116. SIGNATURE OF TRANSPORTATION CLERK

117. SIGNATURE OF PUBLIC WORKS CLERK

118. SIGNATURE OF SANITATION CLERK

119. SIGNATURE OF FIRE PROTECTION CLERK

120. SIGNATURE OF POLICE CLERK

121. SIGNATURE OF JUDICIAL CLERK

122. SIGNATURE OF LEGAL CLERK

123. SIGNATURE OF ACCOUNTING CLERK

124. SIGNATURE OF FINANCE CLERK

125. SIGNATURE OF TAXATION CLERK

126. SIGNATURE OF LABOR CLERK

127. SIGNATURE OF INDUSTRY CLERK

128. SIGNATURE OF ARTS CLERK

129. SIGNATURE OF SCIENCE CLERK

130. SIGNATURE OF LITERATURE CLERK

131. SIGNATURE OF HISTORY CLERK

132. SIGNATURE OF GEOGRAPHY CLERK

133. SIGNATURE OF MATHEMATICS CLERK

134. SIGNATURE OF PHYSICS CLERK

135. SIGNATURE OF CHEMISTRY CLERK

136. SIGNATURE OF MEDICINE CLERK

137. SIGNATURE OF SURGERY CLERK

138. SIGNATURE OF DENTISTRY CLERK

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143. SIGNATURE OF ANATOMY CLERK

144. SIGNATURE OF PHYSIOLOGY CLERK

145. SIGNATURE OF BOTANY CLERK

146. SIGNATURE OF ZOOLOGY CLERK

147. SIGNATURE OF AGRICULTURE CLERK

148. SIGNATURE OF FISHERIES CLERK

149. SIGNATURE OF MINING CLERK

150. SIGNATURE OF MANUFACTURES CLERK

151. SIGNATURE OF COMMERCE CLERK

152. SIGNATURE OF TRANSPORTATION CLERK

153. SIGNATURE OF PUBLIC WORKS CLERK

154. SIGNATURE OF SANITATION CLERK

155. SIGNATURE OF FIRE PROTECTION CLERK

156. SIGNATURE OF POLICE CLERK

157. SIGNATURE OF JUDICIAL CLERK

158. SIGNATURE OF LEGAL CLERK

159. SIGNATURE OF ACCOUNTING CLERK

160. SIGNATURE OF FINANCE CLERK

161. SIGNATURE OF TAXATION CLERK

162. SIGNATURE OF LABOR CLERK

163. SIGNATURE OF INDUSTRY CLERK

164. SIGNATURE OF ARTS CLERK

165. SIGNATURE OF SCIENCE CLERK

166. SIGNATURE OF LITERATURE CLERK

167. SIGNATURE OF HISTORY CLERK

168. SIGNATURE OF GEOGRAPHY CLERK

169. SIGNATURE OF MATHEMATICS CLERK

170. SIGNATURE OF PHYSICS CLERK

BUREAU V. S.

JUL 1 - 1957

RECEIVED

June 10, 1957

June 10, 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6929

CERTIFICATE OF DEATH

06893

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOLLIE Middle MILINDA Last HEARNE				4. DATE OF DEATH Month 6 Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1872	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home				10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Robert H. Smith				14. MOTHER'S MAIDEN NAME Miria J. Hayman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Ira F. Hearne		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) " Insufficiency (c) Hypertensive C.V. Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 57 , to 6-14 , 19 57 , that I last saw the deceased alive on 6-13 , 19 57 , and that death occurred at 5:10 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. Smith M.D.				ADDRESS (Street, city or town, state) Medical Center, Md.			
DATE SIGNED 6/14/57							
PHYSICIAN'S NAME (Type) William B. Smith				Medical Center, Salisbury, Md.			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 6/15/1957		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemtery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR 6-17-57	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

Norman B. Baker

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar	
Robert J. Jones		Male		45		10/15/1912		Baltimore, Md.		Baltimore, Md.		Heart Disease		10/25/1957		10:00 AM		Home		Natural		J. A. Jones		J. A. Jones	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Prescription		Last X-ray		Last Blood Test		Last Urine Test		Last Stool Test		Last Sputum Test	
Teacher		High School		Married		Hypertension		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957	
Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Anthropologist		Signature of Forensic Entomologist		Signature of Forensic Botanist	
10/25/1957		10:00 AM		Home		Natural		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones		J. A. Jones	

BUREAU V. S.

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6930

CERTIFICATE OF DEATH

06894

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Wetipquin</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY G. HORNER</u>				4. DATE OF DEATH Month Day Year <u>June 13 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1881</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>7 20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Louis C. Horner</u>				14. MOTHER'S MAIDEN NAME <u>_____</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT Address <u>Louis Horner, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, } (b) <u>Arteriosclerosis. Heart Disease</u> (c) <u>_____</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Syncope</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/17/57</u> , 19 <u>57</u> , to <u>5/17/57</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u>				DATE SIGNED <u>6/15/57</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				Nanticoke, Maryland <u>6/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wetipquin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wetipquin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Bivalve</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

JUN 25 1957

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6897

CERTIFICATE OF DEATH

06895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WARCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke 23422</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>MARKET STREET.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles M. Hudson</u>				4. DATE OF DEATH <u>June 7 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 9, 1868</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEMIST</u>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>88</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>W. J. HUDSON SR.</u>				14. MOTHER'S MARDEN NAME <u>EMMA A. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS ELIZABETH M. HUDSON, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.9 Acute Dilatation of Heart</u> DUE TO (b) <u>Since Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Spl. Status Hemia</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>2 mon.</u> <u>88 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>293x</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-29</u> , 19 <u>57</u> , to <u>6-7</u> , 19 <u>57</u> , that I lost the deceased alive on <u>6-7</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Abriele</u>				ADDRESS (Street, city or town, state) <u>Medical Center 6. 8. 57</u>			
PHYSICIAN'S NAME (Type) <u>H. Abriele</u>				DATE SIGNED <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GIRDLTREE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u>				ADDRESS <u>Pocomoke, MD.</u>		24a. REC'D BY REGISTRAR <u>Nancy K. Falloway</u>	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>Charles M. Hubbard</i></p>		<p>AGE <i>42</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>June 12, 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>	
<p>DATE OF BIRTH <i>May 15, 1915</i></p>		<p>PLACE OF BIRTH <i>Worcester, Mass.</i></p>	
<p>DATE OF DEATH <i>June 12, 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>	
<p>DATE OF BIRTH <i>May 15, 1915</i></p>		<p>PLACE OF BIRTH <i>Worcester, Mass.</i></p>	
<p>DATE OF DEATH <i>June 12, 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>	

RECEIVED
JUN 12 1957
BUREAU V. 3

6898

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>18 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Hudson</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29 - 1956</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, md</u>	
13. FATHER'S NAME <u>William Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Julia Park</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Julia P. Hudson, Pottsville, md</u>				Address <u>Rural #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/19</u> , 1957, to <u>6/20</u> , 1957, that I last saw the deceased alive on <u>6/20</u> , 1957, and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury, md</u> <u>6/20/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 24/57</u>		<u>Friendship</u>		<u>Snow Hill Rural #2</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Amos</u>				ADDRESS <u>Snow Hill, md</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
<u>JUN 24 1957</u>				<u>Mary H. Holloway</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH—BAYVIEW, 10

BUREAU V. S.

JUN 24 1957

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06897

6931

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Rural Pittsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR Pittsville		Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1				STREET ADDRESS (If rural give location) R.D.# 1			
3. NAME OF DECEASED (Type or Print) (First) ARRIA (Middle) MAY (Last) HUNTINGTON				4. DATE OF DEATH (Month) JUNE (Day) 22 (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 6, 1883		9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months 2 Days 16 IF UNDER 24 HRS. Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pittsville Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Smiley J. Wells				14. MOTHER'S MAIDEN NAME Lwvenia Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. George W. Huntington (Husband) R.D.# 1 Pittsville, Maryland		
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) Myocarditis Chronic (2 yrs) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fractured surg. neck. Left hip 2 yrs ago							
19a. DATE OF OPERATION 9-24-57		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955 , 19 57 , to 6-22 , 19 57 , that I last saw the deceased alive on 6-21 , 19 57 , and that death occurred at 49 M, from the causes and on the date stated above. SIGNATURE Dr. Frank Re Lewis ADDRESS (Street, city, town, state) Willards, Maryland DATE SIGNED June 24 1957							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jun. 25, 1957		NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		LOCATION (City, town, or county) (State) Pittsville, Maryland	
24. REC'D BY REGISTRAR JUN 25 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Reg. No. 10

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Place of death

9. Date of burial

10. Place of burial

11. Name of informant

12. Address of informant

13. Signature of informant

14. Date of completion

15. Place of completion

16. Name of physician

17. Address of physician

18. Signature of physician

19. Date of completion

20. Name of registrar

21. Address of registrar

22. Signature of registrar

23. Name of deceased (repeated)

24. Address of deceased (repeated)

25. Date of completion (repeated)

BUREAU V. 2

JUN 25 1957

RECEIVED

ENCLOSURE

6899
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>W.</u> Last <u>INSLEY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Esau Insley</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Dunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs Levin Wilson Princess ANNE, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5/24/</u> , 19 <u>57</u> , to <u>6/3/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/3/57</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>W. Rollis</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Insley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollings</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

6900

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chance, 19x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Chance, 19x02</u>			
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Maurice</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1951</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Marion Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Catherine Leonard</u>		Address <u>Chance, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Appendix</u> <u>550.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Peritonitis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16, 1957</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eldon G. Markman, M.D.</u>				ADDRESS (Street, city or town, state) <u>Princess Anne, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Eldon G. Markman, M.D.</u>				DATE SIGNED <u>Princess Anne, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Chance, Som. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>				ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name: *Charles*
 Sex: *Male*
 Age: *45*
 Date of Birth: *June 22, 1912*
 Place of Birth: *St. Louis, Mo.*
 Usual Residence: *St. Louis, Mo.*
 Date of Death: *June 22, 1957*
 Place of Death: *St. Louis, Mo.*
 Cause of Death: *Myocardial Infarction*
 Physician: *Dr. J. H. Jones*
 Burial Place: *St. Louis, Mo.*
 Signature: *Charles*

BUREAU V. 2

JUN 28 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06900

CERTIFICATE OF DEATH

Reg. Dist. No.

337

6901

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS Pierce St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First PRESTON Middle WILLIAM Last KILLMON		4. DATE OF DEATH		Month JUNE Day 28th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1924		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Operator (Bait & Tackle-Sporting Goods)				10b. KIND OF BUSINESS OR INDUSTRY Newark, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Seamer Killmon				14. MOTHER'S MAIDEN NAME Mannie Bradford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) W.W. II		17. INFORMANT Mrs. Anna Bella Killmon (Wife) Address Pierce St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 min. 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1956 , to June, 1957 , that I last saw the deceased alive on June 28, 1957 , and that death occurred at 6:55 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.				ADDRESS (Street, city or town, state) 924 N. Division Street Salisbury, Maryland			
DATE SIGNED 6/28/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 1 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

100-443887-100

1032

BUREAU V. S.

JUL 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06901

Reg. Dist. No.

337

6902

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS 316 Carroll St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle Last KOFFEL				4. DATE OF DEATH Month JUNE Day 22 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1st, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 10 Days 21		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Wico. County - Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Milbourne Mitchell				14. MOTHER'S MAIDEN NAME Sarah Hitchens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Raymond Koffel (Husband) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Congestion / Heart Failure DUE TO 904.0 Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease (c), stating the underlying cause lost, DUE TO —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home 6-5-57					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6 5 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUN 25 1957		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Residence		Marital Status	
Heart Disease		Natural		Teacher		123 Main St.		Married	
Date of Death		Time of Death		Place of Death		Physician		Coroner	
Jan 15, 1957		10:30 AM		Home		Dr. J. Smith		Mr. Brown	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its design agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Essex, Va.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>six weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Hill Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First Middle Last		4. DATE OF DEATH <u>6</u> <u>12</u> <u>19 57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William S. Lank Ford</u>		14. MOTHER'S MAIDEN NAME <u>Emily Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr Charles Lankford Essex Co.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>458.1</u> <u>Amputation of right leg at mid-thigh with arterio-sclerotic gangrene.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Arterio-sclerotic gangrene of right leg.</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>4-5</u> <u>19 57</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-17-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>June 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Franktown</u>	
22d. LOCATION (City, town, or county) <u>Franktown</u>		(State) <u>Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fox & James</u> ADDRESS <u>B.B. Fox Eastville Va.</u>		24a. REC'D BY REGISTRAR <u>JUN 19 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			



RECEIVED
JUN 19 1957



BUREAU V. S.

JUN 19 1957

RECEIVED

0690337

6904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>720 Greenwood Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Johanna</u>		Middle <u>Lilly</u>		Last <u>Lilly</u>	
4. DATE OF DEATH		Month <u>June</u>		Day <u>28</u>		Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 5, 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Bartling</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Kreueler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>Old C V A</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/21/</u> 19 <u>57</u> , to <u>6/28/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/28/</u> 19 <u>57</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>6/28/57</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR <u>1</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar, for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CHIEF CLERK [Faint text]	

BUREAU V. 3

JUL 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6905

06904 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Zion Rd				d. STREET ADDRESS Hudson Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM DAVID LITTLETON JR				4. DATE OF DEATH Month Day Year June 11 th 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1950	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 9 7		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John William David Littleton				14. MOTHER'S MAIDEN NAME Mary Ann Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. & Mrs. J. Wm David Littleton (Mother & Father) Hudson, Drive Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture of Skull 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Car					
20c. TIME OF INJURY Month, Day, Year Hour 7:15 p. m. 6-11 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Zion Rd Salisbury		20f. (City or town) (County) (State) Salisbury Wicomico Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L Royer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED June 12 1957			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY MD.				24a. REC'D BY REGISTRAR JUN 13 1957		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John William David Harrison		38		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
1000 North	
Date of Death		Time of Death		Place of Death		Physician	
June 12, 1957		
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of ...	
...		

RECEIVED
JUN 13 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6906

CERTIFICATE OF DEATH

06905

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB 2 1/3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Oremton Farm			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Kathleen Middle THEAESA Last McDonough				4. DATE OF DEATH Month June Day 10 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - NONE		11. BIRTHPLACE (State or foreign country) Albany, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. McDonough				14. MOTHER'S MAIDEN NAME Catherine Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 522X IMMEDIATE CAUSE (a) Hypostatic congestion of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
570.3 Volvulus of the intestine							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 22 , 19 55 , to June 10 , 19 57 , that I last saw the deceased alive on June 9 , 19 57 , and that death occurred at 6:48 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/10/57							
ACTUAL SIGNATURE L. V. Maldve		PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF JUNE 12, 1957		22c. NAME OF CEMETERY OR CREMATORY ST. AGNES CEMETERY		22d. LOCATION (City, town, or county) (State) ALBANY, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Currell		ADDRESS EASTON, M.D.		24a. REC'D BY REGISTRAR JUN 14 57		24b. REGISTRAR'S SIGNATURE W. H. Halloway	

CERTIFICATE OF DEATH

Reg. Dist. No.

33

6907

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23x02			
				d. STREET ADDRESS 101 Tingle Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nettie Middle Hester Last Mills				4. DATE OF DEATH Month June Day 14 Year 19 57			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Domestic			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Bishop				14. MOTHER'S MAIDEN NAME Martha Selby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inoperable mixed tumor of sarcoma and carcinoma 174X DUE TO of the uterus with advanced generalized metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X Hypertensive arteriosclerotic cardiovascular disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 8 , 19 57 , to June 14 , 19 57 , that I last saw the deceased alive on June 14 , 19 57 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sub Juerman M.D. Deer's Head State Hospital 6/14/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		June 18/57		Huts Chapel		Snow Hill, Md	
23. FUNERAL DIRECTOR'S SIGNATURE May & Dennis				ADDRESS Snow Hill, Md		24a. REC'D BY REGISTRAR DATE JUN 18 1957	
				24b. REGISTRAR'S SIGNATURE May F. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 18 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06907

6932

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wiconico		MARYLAND		STATE Maryland		COUNTY Wiconico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hebron		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hebron			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lillian St (At Home)				STREET ADDRESS (If rural give location) Lillian St (At Home)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WILLIAM		(Middle) STEPHEN		(Last) MILLS		(Month) JUNE (Day) 8th (Year) 19 57	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 14, 1887	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months 1 Days 23		IF UNDER 24 HRS. Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer in Lumber Mill			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wiconico Co. Near Hebron, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Rufus Mills				14. MOTHER'S MAIDEN NAME Phillis Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Katie L. Mills (Wife) Lillian St. Hebron, Maryland	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from June 8, 1957 to June 9, 1957 , that I last saw the deceased alive on June 8, 1957 , and that death occurred at 11:15 PM , from the causes and on the date stated above. SIGNATURE Dr. William Enrich ADDRESS (Street, city, town, state) M.D. Main St. Hebron, Maryland DATE SIGNED June 10/57 <i>Dr. William Enrich</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 11, 1957		NAME OF CEMETERY OR CREMATORY Hebron Cemetery		LOCATION (City, town, or county) (State) Hebron, Maryland	
24. REC'D BY REGISTRAR JUN 12 1957		REGISTRAR'S SIGNATURE <i>May H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom part may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

FILE NO.

7030

DECEASED

NAME

DECEASED

AGE

DECEASED

DATE OF DEATH

DECEASED

SEX

DECEASED

DECEASED

DATE OF BIRTH

DECEASED

DECEASED

PLACE OF BIRTH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. 1

JUN 12 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06908

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Rural Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD # 4</u>				d. STREET ADDRESS <u>RFD # 4</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Clayton C. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Maria Leonard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-38-0865</u>		17. INFORMANT Address <u>Mrs. Joseph Parker, Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-15-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/16/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + Johnson Co. Salisbury, Maryland</u> <u>Norman D. Baker</u>				24a. REC'D BY REGISTRAR <u>6-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

RECEIVED

JUN 18 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6908

CERTIFICATE OF DEATH

06909

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Philadelphia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Penninsula Gen. Hosp				d. STREET ADDRESS 615 North 48th St.			
3. NAME OF DECEASED (Type or print) Mary Ola Parson				4. DATE OF DEATH 6 23 1957			
5. SEX F.M.		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/1892	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR 23 Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Pinkett				14. MOTHER'S MAIDEN NAME Leah Ann Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 078 16 7483		17. INFORMANT Mrs. Jean Spence, 648 W. Main St., Salisbury, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular Renal Disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 24 May 1957 , to 23 June 1957 , that I last saw the deceased alive on 23 June 1957 , and that death occurred at 2:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. A. Purnell				DATE SIGNED 23 June 57			
PHYSICIAN'S NAME (Type) E. A. Purnell, 652 W. Main Street				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/57		22c. NAME OF CEMETERY OR CREMATORY Mount Lam Cemetery		22d. LOCATION (City, town, or county) (State) Sharon Hill, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart Funeral Home, S Salisbury, Maryland				ADDRESS 652 W Main St		24a. REC'D BY REGISTRAR 26 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

Page No. 18

DECEASED		DATE OF DEATH		PLACE OF DEATH	
WILLIAM T. HARRIS		JUN 26 1957		BOSTON, MASS.	
AGE		SEX		RACE	
71		M		W	
BIRTH		MARRIAGE		EDUCATION	
JAN 1886		MARRIED		HIGH SCHOOL	
BIRTHPLACE		MARRIAGE PLACE		EDUCATION PLACE	
MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS	
FATHER		MOTHER		SISTER	
JAMES HARRIS		MARY HARRIS		ELIZABETH HARRIS	
BIRTH		BIRTH		BIRTH	
JAN 1850		JAN 1850		JAN 1850	
BIRTHPLACE		BIRTHPLACE		BIRTHPLACE	
MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS	
FATHER		MOTHER		SISTER	
JAMES HARRIS		MARY HARRIS		ELIZABETH HARRIS	
BIRTH		BIRTH		BIRTH	
JAN 1850		JAN 1850		JAN 1850	
BIRTHPLACE		BIRTHPLACE		BIRTHPLACE	
MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS	

BUREAU V. 1

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6909

CERTIFICATE OF DEATH

Reg. Dist. No.

06910
33 ✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> 23X02 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RT. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICIA ALICE Phillips</u>			4. DATE OF DEATH Month Day Year <u>June 12 1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1st 1957</u>	
9. AGE (In years last birthday) <u>12</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>ROBERT PHILLIPS</u>			
14. MOTHER'S MAIDEN NAME <u>SHIRLEY LUDLAM.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> [If yes, give war or dates of service] <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>MRS ROBERT PHILLIPS BERLIN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, intraventricular</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity (Birth Weight 1.86 1003)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1957</u> , to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>57</u> , and that death occurred at <u>10:52 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>976 N. Division St. Salisbury MD</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury MD</u>				DATE SIGNED <u>12 June 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PHILLIPS PRIVATE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN (RFD) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboze</u>				ADDRESS <u>Berlin MD</u>		24a. RECEIVED BY REGISTRAR <u>JUN 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

2082214XVO

CERTIFICATE OF DEATH

DECEASED JAMES EARL RAY		PLACE OF DEATH PENNSYLVANIA GENERAL HOSPITAL	
DATE OF DEATH JUNE 17 1968		TIME OF DEATH 10:15 AM	
PLACE OF BIRTH MOBILE, ALABAMA		AGE 35	
OCCUPATION AIR FORCE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF CLERK [Signature]	

BUREAU V. S.
JUN 17 1968

RECEIVED

06911337

Reg. Dist. No.

DATE JUN 28 1957

BUREAU V. S.

JUN 28 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

6911 Item 7 FilmG217 7-2-57 et
CERTIFICATE OF DEATH

Reg., Dist. No. 837

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL 46x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Pine Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Thomas W. Records</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 21, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store operator</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas S. Records</u>				14. MOTHER'S MAIDEN NAME <u>Nancy V. Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MAMIE M. RECORDS LAUREL, Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated & Bleeding Peptic ulcer</u> <u>540.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 mon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3:18</u> , 19 <u>57</u> , to <u>6:13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6:13</u> , 19 <u>57</u> , and that death occurred at <u>8:58</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H A Briele</u>				M.D. <u>Medical Center</u> <u>6:13-57</u>			
PHYSICIAN'S NAME (Type) <u>H A Briele</u>				<u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harvey Williams</u>				ADDRESS <u>Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>Mary F. Holloway</u>	
				DATE <u>JUN 17 1957</u>			

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. 3

JUN 17 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6912

CERTIFICATE OF DEATH

06913

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 147 Clyde Ave			
3. NAME OF DECEASED (First) (Middle) (Last) IVY SINDEL				4. DATE OF DEATH (Month) (Day) (Year) JUNE 22nd 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar. 22, 1889	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Candy Maker			10b. KIND OF BUSINESS OR INDUSTRY Candy		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Sindel				14. MOTHER'S MAIDEN NAME Cordelia Cassel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. James W. Cassel (Nephew) 147 Clyde Ave Salisbury, Maryland			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
200.1 IMMEDIATE CAUSE (A) Pulmonary edema						12 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized lymphosarcoma						8 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb , 19 57 , to June , 19 57 , that I last saw the deceased alive on June 22, 1957 , and that death occurred at 5:15A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Alberta Mattox				DATE SIGNED June 24/57			
M.D. Camden Ave. Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jun. 24, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR JUN 25 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Manner of Death	
John V. Jones		Male		45		Jan. 15, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		Hospital		Natural	
Occupation		Education		Marital Status		Date of Death		Time of Death		Physician		Hospital		Burial Place		Burial Date	
Clerk		High School		Married		Jan. 20, 1955		10:30 AM		Dr. J. H. Smith		St. Paul's Hospital		St. Paul's Cemetery		Jan. 22, 1955	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Medical Examiner		Signature of Death Officer		Signature of Health Officer		Signature of Clerk		Signature of Secretary	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

RECEIVED
JUN 25 1957
BUREAU V. S.

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0691432

Reg. Dist. No.

6934

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allen (Rural)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico River				d. STREET ADDRESS Eden R.D.# 2			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A Last SMALL				4. DATE OF DEATH Month JUNE Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 29, 1876		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Baltimore County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles W. Small				14. MOTHER'S MAIDEN NAME Mary Jane Alsop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Willard Morris (Daughter) R.D.#2 Eden, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. June 18 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) near Eden Wicomico Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Kendrick McCullough M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Kendrick McCullough				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED June 19 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		22d. LOCATION (City, town, or county) (State) Allen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD:				24. REG'D BY REGISTRAR JUN 21 1957			
				24b. REGISTRAR'S SIGNATURE Mary K. Holloway			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		1957	
Place of Birth		Residence		Cause of Death		Manner of Death		Occupation	
New York		Boston		Heart Disease		Natural		Teacher	
Date of Birth		Date of Death		Time of Death		Place of Death		Signature of Examiner	
1912		1957		10:00 AM		Home		[Signature]	
Physician		Hospital		Coroner		Medical Examiner		Burial Place	
Dr. Smith		St. Mary's		John Doe		John Doe		Cemetery	
Date of Examination		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
1957		1957		1957		1957		1957	

BUREAU V. 2

JUN 21 1957

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06915

6935

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1				STREET ADDRESS (If rural give location) R.D.# 1			
3. NAME OF DECEASED (Type or Print) MARY VIRGINIA SMITH				4. DATE OF DEATH (Month) June (Day) 8 (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 17, 1879		9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months 9 Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac J. Murray				14. MOTHER'S MAIDEN NAME Jane Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or detas of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Wilmer J. Smith (Son) Sharptown, Maryland			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Cardiac insufficiency						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 450.0							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-1, 1957, to 6-8, 1957, that I last saw the deceased alive on 6-7, 1957, and that death occurred at 10:50 P.M., from the causes and on the date stated above. SIGNATURE Dr. William Smith ADDRESS (Street, city, town, state) DATE SIGNED Dr. William Smith M.D. Medical Center - Salisbury, Md. June 10 1957							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 11, 1957		NAME OF CEMETERY OR CREMATORY Fruitland Cemetery		LOCATION (City, town, or county) (State) Fruitland, Maryland	
24. REC'D BY REGISTRAR JUN 12 1957		REGISTRAR'S SIGNATURE <i>Mary K. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Page One of Two

Name of Deceased James J. Murray		Sex Male		Date of Birth August 19, 1909		Place of Birth Bloomington, Maryland		Usual Residence House 4014 of House		Cause of Death Ischemic Heart Disease		Manner of Death Natural		County Baltimore		City Baltimore	
Signature of Physician James J. Murray		Signature of Medical Examiner James J. Murray		Signature of Coroner James J. Murray		Signature of Registrar James J. Murray		Signature of Burial Director James J. Murray		Signature of Undertaker James J. Murray		Signature of Funeral Home James J. Murray		Signature of Cemetery James J. Murray		Signature of Burial Place James J. Murray	

BUREAU V. 1

JUN 12 1957

RECEIVED

RECEIVED - BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06918

6913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>904 MARKET ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>LORENZO</u> Middle <u>T.</u> Last <u>SOMERS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>	9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISSAC SOMERS</u>		14. MOTHER'S MAIDEN NAME <u>DELIAH FRANCES HUGHES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. E. LESTER KIRBY, POCOMOKE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>14 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/11</u> , 19 <u>57</u> , to <u>6/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>57</u> , and that death occurred at <u>8:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>3215 D.W. St.</u> DATE SIGNED <u>6/11/57</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		<u>SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 14, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SALEM M.E. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		ADDRESS <u>POCOMOKE, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES T. SMITH		45		M		W		1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL OPINION	
JULY 15, 1957		HOSPITAL		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DEATH CERTIFICATE	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF JURY	

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,16 Film 0217 7-15-57 et

CERTIFICATE OF DEATH

6914

06918

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 1 1/2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ira Taylor				4. DATE OF DEATH Month Day Year June 30 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/22/1893		9. AGE (In years last birthday) yrs. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Dayton, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Taylor				14. MOTHER'S MAIDEN NAME Amanda ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 212-18-6785		17. INFORMANT 1064 Address Hospital Records & Mrs. Gladys Binette			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 306x Chronic brain syndrome associated with arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1957 to June 30, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman		M.D. Deer's Head State Hospital		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 6/30/57	
PHYSICIAN'S NAME (Type) V. Juerman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) (Port Deposit (Cecil Co.) Maryland)	
23. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON				ADDRESS PERRYVILLE, MARYLAND		24a. REC'D BY REGISTRAR DATE 7/3/57	
				24b. REGISTRAR'S SIGNATURE Mary Holloway			

3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06919

6915

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.N. Gen. Hospital (D.O.A.)				STREET ADDRESS R.D.# 1		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WALTER (Middle) JACOB (Last) TILGHMAN				(Month) JUNE (Day) 21st (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 18, 1899	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer		10b. KIND OF BUSINESS OR INDUSTRY Used Cars		11. BIRTHPLACE (State or foreign country) Somerset County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norman C. Tilghman				14. MOTHER'S MAIDEN NAME Elizabeth E. Pollitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Sara B. Tilghman (Wife) R.D.# 1 Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
416 X IMMEDIATE CAUSE (A) Acute Cardiac decompensation						INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) Rheumatic Heart Disease						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 4343							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 20, 1957 , to June 21, 1957 , that I last saw the deceased alive on June 21, 1957 , and that death occurred at 2:00A. from the causes and on the date stated above.							
SIGNATURE Dr. William D. Gray				ADDRESS (Street, city, town, state) 334 Camden Ave. Salisbury, Md		DATE SIGNED June 22/57	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Jun. 23, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE JUN 25 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Place of Birth [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Cause of Death [Illegible]	
Occupation [Illegible]		Duration of Illness [Illegible]	
Name of Physician [Illegible]		Name of Hospital [Illegible]	
Name of Undertaker [Illegible]		Name of Burial Place [Illegible]	
Name of Coroner [Illegible]		Name of Medical Examiner [Illegible]	

BUREAU V. 2

JUN 25 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle FULTON Last TOWNSEND				4. DATE OF DEATH Month JUNE Day 13 Year th 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1911		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Shad Point, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William J. Townsend				14. MOTHER'S MAIDEN NAME Sara Jane Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louise Townsend (Wife) Address R.D. # 1 (Shad Point) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 162X DUE TO Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mos. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 , 19 57 , to June 13 , 19 57 , that I last saw the deceased alive on June 13 , 19 57 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rufus S. Gardner, Jr.				ADDRESS (Street, city or town, state) 3215 Div. St., Salisbury, Md.			
PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, JR.				DATE SIGNED June 13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		22d. LOCATION (City, town, or county) (State) R.D. # 1 Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24. REGD. BY REGISTRAR JUN 17 1957			
				25. REGISTRAR'S SIGNATURE Mary J. Holloway			

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's signature, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

CERTIFICATE OF DEATH

06921

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1 A7Dues</u>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Julley</u> Last <u>Julley</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucas</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-71</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>James Cameron</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lillian Holloway</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u> <u>Unk.</u> <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 28, 1957</u> , to <u>June 2, 1957</u> , that I last saw the deceased alive on <u>June 1, 1957</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Semple</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>6/3/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Semple</u>				DATE SIGNED <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Backus St. Crest</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUN 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

JUN 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06922

6936

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place) 35 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 2		STREET ADDRESS (If rural give location) RFD # 2					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Norman Edward Twilley				4. DATE OF DEATH (Month) (Day) (Year) June 12 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4-29-1888	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Fred Twilley				14. MOTHER'S MAIDEN NAME Nannie Dishmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 220-32-8504		17. INFORMANT & ADDRESS Edward Twilley, Salisbury, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) Corn						24 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of colon						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1955		19b. MAJOR FINDINGS OR OPERATION Carcinoma of colon				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 12, 1957 , to June 17, 1957 , that I last saw the deceased alive on June 12, 1957 , and that death occurred at 6-13-57 M, from the causes and on the date stated above.							
SIGNATURE S. H. Lynd				ADDRESS (Street, city, town, state)		DATE SIGNED 6-13-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-14-57		NAME OF CEMETERY OR CREMATORY Hastings		LOCATION (City, town, or county) Delmar, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary K. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE W. S. Gamel		ADDRESS Co Delmar, Del	
DATE JUN 18 1957							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. WILSON		2. SEX Male		3. AGE 35 yrs	
4. OCCUPATION Electrician		5. MARITAL STATUS Married		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH JUN 12 1957		8. TIME OF DEATH 10:15 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. M. Wilson	
13. SIGNATURE OF REGISTRAR J. M. Wilson		14. SIGNATURE OF WITNESSES J. M. Wilson		15. SIGNATURE OF FUNERAL HOME J. M. Wilson	

BUREAU V. 21

JUN 18 1957

RECEIVED

EXHIBITION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06923

6918

Item 9 Film G216 6-19-57 et

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>not known</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Wade</u> Last <u>Wade</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 35-40</u> yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural and Subarachnoid Hemorrhage</u> 904.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of Skull</u> (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>scuffle in tavern, details not obtained.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3:10</u> p. m. <u>May 31, 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>tavern</u>	
		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE <u>Kendrick Mc Cullough</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Kendrick Mc Cullough</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. W. ...</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>JUN 17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

22

2

BUREAU V. S.

JUN 17 1957

RECEIVED

6919

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 304 Maryland	
3. NAME OF DECEASED (Type or print) First NANNIE Middle CANTWELL Last WALLER		4. DATE OF DEATH Month 6 Day 4 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Cantwell		14. MOTHER'S MAIDEN NAME Sallie Cantwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-26-5282	
17. INFORMANT Mr. Wallace Waller, Forrest Hgts. Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 332X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4 , 19 57 , to 6/4 , 19 57 , that I last saw the deceased alive on 6/4/57 , 19 57 , and that death occurred at 9:50 p. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Gramse		ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 6/4/57	
PHYSICIAN'S NAME (Type) Fred R. Gramse		S. Division St., Salisbury, Maryland	
22a. BURIAL, CREMATION, REPOSE (Specify) BOYD CEMETERY		22b. DATE THEREOF 6/6/1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE 6-6-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloman	

Normant Baker



RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06925
Reg. Dist. No. 237

6920

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 12			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Salisbury Blvd. U.S. Route # 13				d. STREET ADDRESS 1 Spring Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SERMON		First LINWOOD		Last WHITE		4. DATE OF DEATH Month JUNE Day 11 Year 19 57	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 20, 1910	
				9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Bread Co. (Treihofers)				10b. KIND OF BUSINESS OR INDUSTRY Sussex County Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charlie Linwood White				14. MOTHER'S MAIDEN NAME Annie V. Kenny			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.# 214-10-7817		17. INFORMANT Mrs. Katherine B. White (Wife) Spring Hill Rd. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trunk struck pole & turned over on him					
20c. TIME OF INJURY Month, Day, Year 2/13 6-11 19 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Blvd		20f. (City or town) Salisbury (County) Wicomico (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memorial Gardens		22d. LOCATION (City, town, or county) (State) R.D. # Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR June 13 1957		24b. REGISTRAR'S SIGNATURE May H. Holloway	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - JEFFERSON 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		June 13, 1957	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St., St. Louis, Mo.		Teacher		Heart Disease		Natural	
Physician		Hospital		Time of Death		Place of Death	
Dr. J. Smith		St. Louis Hospital		10:00 AM		St. Louis, Mo.	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUN 13 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06926

532

6921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>735 Newton St.</u>		d. STREET ADDRESS <u>1 735 Newton St.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>F.</u> Last <u>WILKINS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1884</u>
		9. AGE (In years lost birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josephus ELLIOTT</u>		14. MOTHER'S MAIDEN NAME <u>ADDIE T. ELLIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. H. E. PARSONS</u>		Address <u>SALIS, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>"</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
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19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>No 1</u> , 19 <u>57</u> , to <u>June 13, 1957</u> , that I last saw the deceased alive on <u>June 13, 1957</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.	DATE SIGNED <u>June 15, 1957</u>
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Williams</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Gallagher</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

JUN 18 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06927

6937

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MARDELA</u>		LENGTH OF STAY (In this place) <u>2 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SHARPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANZIE WINDSOR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-20-57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-6-1868</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. J. KNOWLES</u>				14. MOTHER'S MAIDEN NAME <u>PRISCILLA VINCENT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>LUCKY GRAVENOR-SHARPTOWN</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
290.0 IMMEDIATE CAUSE (A) <u>Pernicious Anemia</u>						<u>1 year.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 20, 1957</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>1120P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Kuhlman</u> M.D.				ADDRESS (Street, city, town, state) <u>Sharptown Md</u>		DATE SIGNED <u>6/22/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-23-57</u>		NAME OF CEMETERY OR CREMATORY <u>ST MARKS</u>		LOCATION (City, town, or county) <u>LAUREL DEL</u>	
24. REC'D BY REGISTRAR <u>JUN 25 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Garmel</u>		ADDRESS <u>Sharptown Md</u>	

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1957

DATE OF DEATH

PLACE OF DEATH

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JUN 25 1957

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